STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 000	INITIAL COMMENTS	A 000		

This Statement of Deficiencies was generated as a result of a mid-cycle Joint Commission of Accreditation of Health Care Organizations (JCAHO) which resulted in a Validation Survey conducted at your facility from July 22, 2008 through July 25, 2008.

The sample size was 45 patients, including 10 closed patient records.

It was determined the facility did not meet the Condition of Participation at CFR (Code of Federal Regulations) 482.42: Infection Control (TAG A 747).

The facility failed to:
- Implement and follow policies to control infections
- Ensure that a safe and sanitary environment was provided to protect the health and safety of patients
- To have a consistent and comprehensive system for identifying, reporting, investigating, and controlling infections and communicable disease in patients and employees.

The cumulative effect of these systemic practices resulted in the facility's failure to provide acceptable standard infection control services to its patients.

The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.

The following regulatory deficiencies were

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

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A 000	Continued From page 1	A 000		
	identified:			
A 265	482.21(a)(1) QAPI HEALTH OUTCOMES The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Quality Assessment and Performance Improvement Program included a comprehensive ongoing program that showed measurable improvement in indicators for which there was evidence that would improve health outcomes for the Rehabilitation Department and Infection Control regarding Outpatient Endoscopy and Cardiac Catheterization. Findings include: Record Review On July 25, 2008 during review of the Quality Management Program, there was no documented evidence that the Rehabilitation Department participated in the Quality Assurance and Performance Improvement Program. Interview On July 25, 2008 in the morning, an interview was conducted with the Director of Quality	A 265		9/24/08

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

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MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 265	Continued From page 2	A 265		

Management (DQM) and two of the Quality Management Coordinators. The DQM indicated the facility conducted an ongoing program with measurable improvement indicators for which there was evidence to identify and reduce medical errors, track adverse events, and monitor the effectiveness and safety of services and quality of care. The DQM further indicated the Nurse Managers and Directors of the Departments were responsible to collect data and submit Performance Improvement and other measurable quality data to the Quality Improvement Department, which met quarterly. The DQM revealed she had not received a Performance Improvement (PI) indicator or any comprehensive program that showed measurable improvement from the Rehabilitation Department for at least the previous two years.

On July 25, 2008 in the morning, the Director of Nursing (DON) and the Regulatory Compliance Officer revealed they had not received any documentation concerning Performance Improvement or a comprehensive program showing measurable goals or outcomes from the Rehabilitation Department for a number of years.

On July 25, 2008 in the afternoon, the Infection Control Officer revealed she had no evidence of documentation for Performance Improvement, tracking and trending, or surveillance of infection monitoring for the Outpatient Endoscopy Services or the Cardiac Catheterization Outpatient Services. Upon questioning specifically whether the facility had a system in place for monitoring of infection control for outpatients who had undergone an endoscopy and/or cardiac catheterization procedures at the facility, the Infection Control Officer responded negatively,

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MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 265	Continued From page 3 and revealed there had not been a system in place since she was employed at the facility as the Infection Control Officer (October 23, 2006).	A 265		
A 404	482.23(c) ADMINISTRATION OF DRUGS Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician's orders (Patient #36). Findings include: Observation On 7/23/2008 in the morning, Patient #36 had a Heparin lock intravenous (IV) access to her left upper extremity. There was no IV bag connected to the heparin lock access site or an IV bag in the room for Patient #36. Record Review Patient #36's Medication Kardexes dated 7/22/2008 to 7/23/2008 and 7/23/2008 to 7/24/2008 documented:	A 404		9/24/08

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 404	Continued From page 4 - " ...D5 0.45% NACL (Dextrose 5% with 0.45 sodium chloride) 70 ml/HR (hour) ..." There was no documented evidence IV fluids for Patient #36 were supposed to be discontinued. Interview On 7/23/2008 in the morning, the Director of Medical Surgical Services confirmed Patient #36 had orders for IV fluids to be infused at 70 ml/hr.	A 404		
A 442	482.24(b)(3) SECURITY OF MEDICAL RECORDS [Information from or copies of records may be released only to authorized individuals,] and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an area for medical records in which unauthorized individuals could not gain access to patient records. Findings include: 1. Medical Records Department Observation The main entrance to the Medical Records	A 442		9/24/08

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A 442	Continued From page 5 Department was accessed through a main administrative hallway. The Physicians' Lounge was adjacent to the Medical Records Department and had a direct entrance to the Dictation Room. The Dictation Room had an entrance to the main storage area of the Medical Records Department. On 7/22/08, 7/23/08, 7/24/08, and 7/25/08, the doors leading from the Physicians' Lounge to the Dictation Room and from the Dictation Room to the Medical Records storage area was ajar and unlocked. On 7/24/08 in the morning, a staff member from the Administrative Department was observed accessing the Physicians' Lounge using the door from the hallway to the Physicians' Lounge and using the numerical coded lock mechanism. On 7/24/08 in the morning, a housekeeping staff member was observed vacuuming in the Physicians' Lounge. Interview On 7/23/08 and 7/24/08, the Director of Medical Records stated the Medical Records Department hours for public access were 8am-6pm Monday through Friday, and the department was staffed from 8am-8pm, 7 days a week. The Director further stated the doors leading from the Physicians' Lounge to the Dictation Room and to the Medical Records storage area were maintained in an ajar, unlocked position from 8am-8pm, 7 days per week. On 7/24/08, the Director of Medical Records indicated the following persons from different departments of the hospital had access with keys	A 442		

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A 442	Continued From page 6 to the door to the Physicians' Lounge and the Medical Records Department: Security personnel, Housekeeping personnel, and administrative staff, including clerical staff. The Director of Medical Records further revealed there was no security measure in place and implemented by the facility to ensure that the janitorial, security and administrative staff members did not gain unsupervised access to patients' medical records. 2. Emergency Room: Observation On 7/22/08 at 2 PM, in the Emergency Room (ER) at the main nurses' station, 2 computer screens were observed facing the hallway with patient-specific information visible on the computer screens. No hospital personnel were observed in front of the screen. The information stayed visible for approximately 7 minutes. On 7/22/08 at 2:56 PM, in the rear ER nurses' station, a computer screen facing the hallway was observed with patient information visible for approximately 4 minutes. A physician assistant subsequently approached the computer terminal, typed information into the computer, and walked away, leaving patient-specific information visible, including a list of patient names and diagnoses. The information remained visible for at least 5 minutes until the screen saver appeared on. On 7/23/08 at 4:00 pm, 2 computer screens were observed on and facing the hallways with patient-specific information on the screens. No hospital personnel were observed using the computers at the time and the information remained visible for 4-7 minutes.	A 442		

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A 442	Continued From page 7 On 7/24/08 at 8:39 am, 2 computer screens with patient-specific information were observed on at the main nurses' station and the rear nurses' station. No hospital personnel were observed using the computers at the time and the information remained visible for 4-7 minutes. During the observations on 7/22/08, 7/23/08 and 7/24/08, multiple patients and visitors were observed walking throughout the hallways who had potential access to the computer screens without staff present at the nurses' stations to directly monitor the computers. Interview On 7/22/08 at 2:30, the charge nurse indicated the computer screens usually went off after 1 minute of being idle. The charge nurse also indicated staff were instructed to close the screen before walking away from the terminal.	A 442		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all entries in the medical record were legible, complete, authenticated, and dated promptly by the person who was responsible for ordering, providing, or evaluating the services furnished for 2 of 45 patients	A 450		9/24/08

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

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A 450	Continued From page 8 (Patients #12, #14). Findings include: Record Review Patient #14 Review of the medical record of Patient #14 revealed physician's progress notes dated 7/20/08, 7/21/08, and 7/22/08 were only partially legible. The physician's signature was totally illegible and appeared to resemble an "X" on both the progress notes and the physician's orders. There was no name stamp used to clearly identify the physician. Patient #12 Review of the medical record of Patient # 12 revealed the physician's progress notes dated 7/22/08 were only partially legible. The physician's signature was totally illegible and appeared to resemble an "X" on both the progress notes and physician orders. There was no name stamp used to clearly identify the physician. Interview On 7/23/08, the charge nurse on the 3rd floor was asked to read the physician progress notes for Patient # 12 and she stated she was unable to read all the notes. The charge nurse stated this physician ' s orders were very clear but it was frequently difficult to read his progress notes. The charge nurse was able to identify the doctor based on the signature since she was familiar with the doctor's signature. The charge nurse referred to a list available in the hospital on the	A 450		

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

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A 450	Continued From page 9 5th floor which had physicians' signatures and full name listed for easy identification, however, this list was not available on the charge nurse's unit.	A 450		
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure outdated or otherwise unusable drugs and biologicals were not be available for patient use. Observation On July 22, 2008 in the afternoon, the following was observed: - 6 Chlorapreps with Tint with an expiration date of May 2008 were found during an inspection of the crash carts in the 3rd floor South Unit. - 5 Clorapreps with Tint with expired dates (two dated February 2008, two dated March 2008, and one dated May 2008) were found in the crash cart located in the Progressive Care Unit. - The clean supply room located in the Progressive Care Unit had 7 expired peritoneal dialysis 2000 ml (milliliter) bags stored in the lower bin. Six bags had an expiration date of February 2008 and one bag had an expiration date of November 2007.	A 505		9/24/08
A 747	482.42 INFECTION CONTROL	A 747		9/24/08

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A 747	Continued From page 10 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, interview, record review, and document review, the facility failed to provide a sanitary environment, failed to follow policies and procedures to avoid sources and transmission of infections and communicable diseases, and failed to have an active program for the prevention, control and investigation of infections and communicable diseases in the procedures area. Findings include: 1. Medication Cart in the Isolation Room Observation On 7/25/08 at 8:35 am on the 5th floor A Pod, the medication nurse (Employee #26) was observed passing medications in Room #547, which was occupied by Patient #19. Patient #19 was on contact isolation for MDRO	A 747		

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

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A 747	Continued From page 11 (Multi-Drug Resistant Organism). Employee #26 was observed inside the room with appropriate isolation attire including, disposable gown, gloves and mask. The medication cart was inside the room next to the patient's bed. When Employee #26 finished dispensing the medications, she removed the gown, gloves and mask, and disposed of the items in the room. She then pulled the medication cart into the hallway. She proceeded to wash her hands. Without wiping down the medication cart, Employee #26 nurse proceeded to push the cart into the next patient's room (Room #545) to dispense medications for that patient. Interview On 7/25/08 at 8:40 am, the clinical manager who was present at the time the nurse was in the isolation room stated that it was the policy for the nurse to wipe down the cart with antiseptic after the cart was removed from an isolation room. Document Review The Hospital Policy # IC36 (Multi-Drug Resistant Organism (MDRO) Orders and Special Contact Isolation - Section IV, C, 7 b. Non-Patient specific, Reusable equipment revealed, created 4/12/07, edited 4/24/07): "Equipment brought into a isoation (isolation) room for periodic use will be limited to only necessary items. Wipe down equipment entirely with hospital approved germicide soaked cloth and allow to air dry before removing from room. Contaminated reusable equipment may be handled using one of the following three methods: 1) Avoid contaminating item by covering it with a drape or by touching it only with clean hands or a	A 747		

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A 747	Continued From page 12 'transfer paper'; 2) Bag in a clear plastic bag with ISOLATION label and send to Sterile Processing. (Appropriate if item is ordinarily processed there). 3) Disinfect item before removing it from the room, using the disinfectant supplied on the isolation cart for items that Sterile Processing does not ordinarily disinfect. (Examples of this are portable chest x-ray machine and cassette, pule (pulse) ox), ... " 2. Cardiac Catheterization Lab Observation On 7/25/08 at 9:35 am, in the Cardiac Catheterization (Cath) Lab prior to the subsequent procedure, 4 drops of blood were observed at the foot of the procedure table. The drops were small in size, approximately 0.5 millimeter (mm) in diameter, and bright red in color. The drops were observed at the end and to the left of the procedure table. On the right side of the foot of the procedure table, 3 pieces of small white paper and a plastic cap that covered the insertion port of an intravenous (IV) bag of fluid were lying on the floor. The pieces of paper and the plastic cap were close to the base of the procedure table. A registered nurse (RN) placed the paper and plastic cap in a trash container after she was asked what it was doing on the floor. Interview On 7/25/08 at 9:40 am, staff in the cath lab reported, "We mop up after every case."	A 747		

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A 747	Continued From page 13 On 7/25/08 at 2:35 pm, the Director of Cardiac Services reported the cath lab staff was responsible for cleaning the rooms "after each case." The cleaning described included the "trash, floor, wiping everything down." There was inadequate cleaning of the cardiac catheterization lab on 7/25/08 in between morning cases, resulting in an environment that was not sanitary and did not prevent a potential exposure to a source of infections. 3. Outpatient Endoscopy and Cath Lab Infection Control Monitoring Interview On 7/23/08 at 3:20 pm, the Director of Surgical Services reported "all patients are treated the same. There are no out patients per say." The director went on to indicate there was no outpatient surgery department only outpatient services for "blood draws and x-rays." On 7/25/08 at 8:00 am, the Director of Surgical Services indicated "the pre-op (pre-operative) RN does a follow-up phone call within 24 hours staffing permitting" for patients who had an EGD (esophagastroduodenoscopy), colonoscopy, or a procedure in the cardiac catheterization lab who were not hospital in-patients. Once the follow-up phone call was completed, there was no other contact with the patient(s). The Director of Surgical Services reported there was no hospital-based monitoring of potential post-procedure infections for patients who were not hospital in-patients. On 7/25/08 at 11:12 am, the Infection Control	A 747		

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A 747	Continued From page 14	A 747		

Officer indicated there was no infection control follow-up for patients who were not hospital in-patients and had an EGD, colonoscopy, or a procedure in the cardiac catheterization lab.

On 7/25/08 at 2:35 pm, the Director of Cardiac Services indicated that there was no infection control follow-up procedure conducted for patients who had procedures in the Cardiac Catheterization Lab who were not inpatients.

There was no active program for the control or investigation of infections and communicable diseases for those patients who were not hospital in-patients but had an EGD, colonoscopy, or a procedure in the Cardiac Catheterization Lab within the surgical services area.

4. Outpatient Laboratory

Observation

On July 24, 2008 in the morning, a phlebotomist in the Outpatient Laboratory did not cleanse her hands before drawing a patient, following contact with an inanimate object. The following was observed:

After drawing a patient's blood and processing the specimen, the phlebotomist kept her gloves on while typing on the computer keyboard. The phlebotomist removed the gloves and used an alcohol-based hand sanitizer to cleanse her hands. The phlebotomist then typed on the same computer keyboard, called the next patient, and donned another pair of gloves and proceeded to draw that patient, without cleansing her hands.

Document Review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 747	Continued From page 15 The facility'spolicy indicated the following, "HAND HYGIENE POLICY (Effective May 2003, Revised February 4, 2004, December 21, 2007): I. SCOPE: Housewide II. PURPOSE: The policy delineats (delineates) proper hand hygiene practices of health care workers and to reduce transmission of pathogenic microorganisms to patients and personnel in health care settings. III. POLICY: In compliance with the Centers for Disease Control recommendations hand hygiene is considered the single most important procedure in preventing nosocomial infections. Antiseptic hand cleaners will be utilized in areas where hand washing facilities are not readily available. IV. PROCEDURE: A. Indications for hand washing and hand antisepsis: 1. When hands are visibly soiled, wash hands with soap and warm water. 2. If hands are not visibly soiled, use and alcohol based hand rub for routinely decontaminating hands. 3. Wash or use alcohol based rub on hands: a. Before and after direct patient contact. b. Donning sterile gloves when inserting intravascular catheters, indwelling urinary catheters, or other invasive devices. c. After contact with a patient's intact skin (e.g. taking pulse, blood pressure and lifting a patient. d. After contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled. e. If moving from a contaminated body site to a clean body site during patient care. f. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. g. After removing gloves and/or other protective clothing. h. Before and after using a restroom, wash hands with soap and water. i. After blowing or wiping the	A 747		

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 747	Continued From page 16 nose. j. Upon leaving an isolation area or after handling articles from an isolation area. k. Upon leaving the work area."	A 747		

5. Operating Room (OR)

Observation

On 7/23/2008 at 12:10 pm, a Laminectomy was performed on a patient in OR #4. Dressed in sterile attire were the physician, two physician assistants and a surgical technician. A second surgical technician, Employee #18, entered OR #4 and donned a sterile gown and sterile gloves. Employee #18 proceeded to assist the physician and physician assistants with the surgery. Employee #18 handled bloody instruments and bloody gauzes which the physician and physician assistants were using on the patient. When the surgery was completed, Employee #18 exited the OR to obtain a hospital bed to transfer the patient on. While wearing the same gown and gloves, Employee #18 opened the OR door with his soiled gloves, then walked out of OR #4 into the hallway and returned with a hospital bed. Employee #18 pushed the hospital bed by holding onto the hand grasp located at the foot of the hospital bed.

Interview

On 7/23/2008 at 12:15 pm, Employee #18 indicated he should have taken off his gloves first before leaving the OR. Employee #18 added that the physicians were always in a hurry.

On 7/23/2008 in the afternoon, the Director of Surgical Services confirmed that it was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 747	Continued From page 17 appropriate to leave the OR with soiled gloves to obtain a bed in the hallway. 6. Lack of Used Intravenous (IV) Bag Disposal Observation/Interview On 7/25/08 in the morning, within the OR area and inside the anesthesia room were several intravenous (IV) bags that were spiked with IV tubing hanging on IV poles. One IV pole had 4 spiked IV bags labeled 0.9 NS (normal saline) 1000 ml (Milliliters). The first IV bag was dated 7/18/2008, the second 7/21/2008, the third 7/23/2008, and the last IV bag was dated 7/24/2008. The anesthesia technician indicated that IV bags were prepared by the anesthesia technicians everyday and it was the responsibility of the anesthesia technician to discard old IV bags every morning. The anesthesia technician indicated that the four 0.9 NS IV bags hanging were still good and ready to be used for cases. A 0.9 NS 500 ml IV bag that was spiked with an IV tubing was hanging on an IV pole along side the four IVs of 0.9 NS 1000ml IV bags. The 0.9NS 500ml IV bag was not dated. The anesthesia technician indicated that the 0.9NS 500ml IV bag was used for cardiac surgeries. The anesthesia technician indicated that the IV bag was not good and needed to be discarded because it had been hanging on the IV pole for a few days. On another IV pole were five IV bags, which were not dated but spiked with Arterial line tubing. The Anesthesia Technician indicated that 2 of the bags were not good and 3 of the bags were ready	A 747		

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

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A 747	Continued From page 18 to be used. On 7/25/2008 in the morning, Anesthesia Technicians were not aware how long the IV bags were good for after they were spiked with IV tubing. The Anesthesia Technicians indicated that nurses had access to the anesthesia room and could obtain a spiked IV bag if it was needed. On 7/25/2008 in the morning, the Director of Surgical Services indicated that IV bags should be dated when the bag was spiked with IV tubing and the spiked IV bag should be discarded after 24 hours. Document Review The hospital policy and procedure regarding Peripheral Intravenous Therapy with a revised date of May 2000 documented: -" ...G. IV tubing shall be labeled with time and date of placement at the time of initiation and changed every 72 hours. Documentation will be on the IV tubing. I. IV solutions will be changed every 24 hours..." 7. Leaking IV bags in Patient #10 and #11's Room: Observation On 7/22/2008 in the afternoon, Patient #10 and Patient #11 shared one room. Patient #10 was assigned to bed A and Patient #11 was assigned to bed B. Between the beds was one intravenous (IV) pole that had 4 IV bags hanging on the pole.	A 747		

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

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MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 747	Continued From page 19	A 747		

Next to the pole was a chair that had an open IV bag labeled Ceftriaxone 1000 mg (milligrams)/50 ml (milliliters) with Patient #10's name on the label. The IV bag had no IV tubing connected to the port and leaked fluid onto the chair.

Hanging on the right side of the pole closest to Patient #10 was Patient #11's IVs. A 50 ml IVPB (intravenous piggyback) bag containing D5W (5% Dextrose in Water) Magnesium Sulfate 2 gm (grams) was labeled with Patient #11's name and dated 7/22/2008. The IVPB was connected to a flush solution of D5 0.45 (5% Dextrose in 0.45 Normal Saline) 1000 ml bag. The IV tubing was not labeled with the time and date and was disconnected from Patient #11. The tubing was curled once on the top bar of the IV pole. The end of the IV tubing was not capped and was left open to air.

Hanging on the left side of the pole closest to Patient #11 was Patient #10's IVs. A 50 ml IVPB bag containing Ceftriaxone 1000mg/50ml was labeled with Patient #10's name and dated 7/22/2008. The IVPB was connected to a flush solution of 0.9 NS (normal saline) 1000 ml bag. The IV tubing connected to the flush bag of 0.9NS was dated 7/10/2008. The tubing was curled once on the top bar of the IV pole. The end of the IV tubing was not capped and was left open to air.

Interview

On 7/22/2008 in the afternoon, the charge nurse indicated that IV tubing was changed every 72 hours. The charge nurse confirmed that Patient #10's IV tubing dated 7/10/2008, should have been discarded 72 hours after it was dated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 747	Continued From page 20 Observation/Interview On 7/23/2008 in the morning, while touring the 5th floor medical surgical unit pod B area with the Director of Medical Surgical Services, 3 patients were noted with their IV tubing disconnected and hanging on the IV poles. There were no caps connected to the ends of the IV tubing. On 7/23/2008 in the morning, a registered nurse (RN) assigned to the area was questioned why Patient #35's IV tubing was disconnected. The RN indicated that the IV was disconnected due to morning care and she would reconnect the tubing when care was completed. Subsequently, the Director of Medical Surgical Services indicated to the staff that the IV bags and tubing that were disconnected and not capped, were to be discarded. The Director indicated that new IV bags were to be hung for the patients observed. 8. Tuberculosis Record Review Employee #25 was employed as a Registered Nurse (RN) 11/3/03. The employee's file contained the following documentation regarding Tuberculosis testing: A one-step Mantoux Tuberculosis skin test was administered on 1/31/07 and read on 2/3/07 with 14 millimeters (mm) results. The Clark County Health District TB (Tuberculosis) Treatment and Control	A 747		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 747	Continued From page 21	A 747		

Department form dated 3/13/07, indicated that Employee #25 was a "Converter," and that INH (Isonicotinic Acid Hydrazide) therapy was recommended but not started. There was no documented evidence that Employee #25 received treatment and/or therapy following the positive tuberculin results in 2007. There was no documented evidence that the employee was screened by a medical professional for signs and symptoms of active Tuberculosis following the positive conversion.

Interview

On 7/24/08 in the afternoon, the Infection Control Nurse stated that she was aware of the employee's positive tuberculin testing results; however, she was unsure whether the positive results were due to the employee's exposure to Tuberculosis. The Infection Control Nurse further verified that Employee #25 did not receive treatment and/or therapy following the positive tuberculin results in 2007.

Document Review

TUBERCULOSIS POLICY (MYCOBACTERIUM TUBERCULOSIS), (Effective February 1, 1996, Revised April 15, 1998, April 2000, December 2001, April 7, 2004, December 21, 2007.):
I. SCOPE: Housewide
II. PURPOSE: A. To establish guidelines for the prevention and control of tuberculosis for patients, employees, medical personnel and visitors. B. To develop practices to prevent transmission as the undiagnosed or unsuspected case may present a significant risk to personnel and other patients. C. Establish TB screening criteria for all patients entering the hospital. C. Prevent transmission of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 747	Continued From page 22 any undiagnosed or unsuspected cases of TB. 9. Observation On 7/22/2008 in the afternoon, a 50 ml IVPB (50 milliliter intravenous piggyback) bag containing D5W (5% Dextrose in Water) Magnesium Sulfate 2 gm (grams) was labeled with Patient #36's name and dated 7/22/2008. The IVPB was connected to a flush solution of D5 0.45 (5% Dextrose in 0.45 Normal Saline) 1000 ml bag. The IV tubing was not labeled with the time and date and was disconnected from Patient #36.	A 747		
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure the Infection Control Nurse implemented the facility's policies and procedures regarding Tuberculosis (TB) screening and treatment of a hospital employee. Findings include: Record Review Employee #25 was employed as a Registered Nurse (RN) on 11/3/03. The employee's file contained the following documentation regarding Tuberculosis testing: A one-step Mantoux Tuberculosis skin test was	A 748		9/24/08

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 748	Continued From page 23 administered on 1/31/07 and was read on 2/3/07 with 14 millimeters (mm) results. The Clark County Health District TB (Tuberculosis) Treatment and Control Department form dated 3/13/07, indicated that Employee #25 was a "Converter", and that INH (Isonicotinic Acid Hydrazide) therapy was recommended but not started. There was no documented evidence that Employee #25 received treatment and/or therapy following the positive Tuberculin results in 2007. There was no documented evidence that the employee was screened by a medical professional for signs and symptoms of active Tuberculosis following the positive conversion. Interview On 7/24/08 in the afternoon, the Infection Control Nurse stated that she was aware of the employee's positive Tuberculin testing results; however, she was unsure whether the positive results were due to the employee's exposure to Tuberculosis. The Infection Control Nurse further verified that Employee #25 did not receive treatment and/or therapy following the positive Tuberculin results in 2007. Document Review The facility's policy indicated the following, "TUBERCULOSIS POLICY (MYCOBACTERIUM TUBERCULOSIS), (Effective February 1, 1996, Revised April 15, 1998, April 2000, December 2001, April 7, 2004, December 21, 2007.): I. SCOPE: Housewide II. PURPOSE: A. To establish guidelines for the prevention and control of tuberculosis for patients,	A 748		

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	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 748	Continued From page 24 employees, medical personnel and visitors. B. To develop practices to prevent transmission as the undiagnosed or unsuspected case may present a significant risk to personnel and other patients. C. Establish TB screening criteria for all patients entering the hospital. C. Prevent transmission of any undiagnosed or unsuspected cases of TB."	A 748		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and document review, the facility failed to ensure that the Infection Control Officer developed and implemented a comprehensive system for identifying, reporting, investigating, and controlling infections of patients and personnel. Findings include: Document Review The Infection Control Health Nurse was employed 10/23/06.	A 749		9/24/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 749	Continued From page 25 The "Annual Infection Control Evaluation 2007 and 2008 Goals" report, prepared by the Infection Control Health Nurse, dated 2/4/08, included the following information: 2007 Goals: 1. Participate in HCA MRSA project. 2. Intense hand hygiene monitoring in conjunction with MRSA project. 3. Participate in the Safe Critical Care Initiative - 5 Million Lives Campaign in collaboration with Vanderbilt University Mountain View's focus surveillance will be Ventilator Associated Pneumonia (VAP) and Catheter Related Bacteremia (CR-BSI). 4. Monitor all in-patients post surgical wound site infections. 5. Outpatient procedures - continue to monitor laparoscopic cholecystectomies. 6. Continue to monitor C-Diff infections. 7. Continue to monitor catheter-related Urinary tract infections. 8. Roll out program to comply with Joint Commission stand IC-4.15 regarding influenza vaccination effectiveness and increasing participation for employees. INFECTION CONTROL REPORTS: Indicated that: Goals which were met: Hospital Acquired infections/overall goal was less than 5%; Surgical Site Infections/goal was =<2%; Vent-related Pneumonia/goal was=<5.1%; Post Delivery Endometritis/goal was <0.5%. Goals which were not met: Bacteremia/goal was =<2.4%; Foley/Goal was =<4%.	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 749	Continued From page 26 Indicated that: Outpatient Monitoring: Outpatient Laparoscopic cholecystectomies were the only outpatient procedure with consistently tracked outcomes by the Infection Control Health Nurse of any post-op results of infections post-op. 2007 Communicable Diseases reported to Southern Nevada Health District (SNHD): Hepatitis C represents the leading communicable disease reported to SNHD from Mountain View Hospital. Employee Health: Annual TB Risk Assessment..."Annual TB screening was conducted on all employees. There were no conversions for the year 2007. Mountain View remains a low risk facility for pulmonary TB, and no change in current TB protection activities or screening criteria is indicated..." "Infection Control Policies and Procedures were reviewed and approved by Infection Control Committee, MEC, and Board of Trustees." Committee Structure: "The committee structure has been reviewed by the Infection Control Committee and believed to be adequate and effective in the management of all Infection Control issues for the hospital." CONCLUSION: "Mountain View Hospital Infection Control Program continues to be a hospital-wide program encompassing all aspects of care and surveillance. 2007 was a year full of new activity and special projects, many of which will continue in 2008. With support from Administration and the Medical Executive Committee, the Infection Control Department believes that all Infection Control issues were appropriately and effectively	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 749	Continued From page 27 managed in a timely fashion." The 2008 Goals, dated February 4, 2008 and revised by the Infection Control Health Nurse 2/27/08, indicated: "1. Continue with participation in HCA MRSA project to obtain 95% compliance rate. 2. Intense hand hygiene monitoring in conjunction with MRSA project for 85% compliance rate before and after hand hygiene. 3. Continue surveillance of Ventilator Associated Pneumonia (VAP) to stay below our benchmark goal of =<5.1%. 4. Continue with surveillance of Catheter Related Bacteremia (CR-BSI) to stay below our benchmark goal of =<2.4%. 5. Monitor all in-patient post surgical wound infections and stay below our benchmark goal of =<2%. 6. Continue to monitor out-patient laparoscopic cholecystectomies for return of questionnaires from phsicians (physicians) of =<85%. 7. Continue with C-diff monitor to stay below our benchmark goal of =<1.5%. 8. Continue to monitor Foley-related Urinary tract infections to stay below our benchmark goal of =<4%. a. Implement hospital-wide use of silver-impregnated foley catheter insertion trays." 1. Employee #25 Record Review Employee #25 was employed as a Registered Nurse (RN) 11/3/03. The employee's file contained the following documentation regarding Tuberculosis testing: A one-step Mantoux Tuberculosis skin test was administered on 1/31/07 and was read 2/3/07 with 14 millimeters (mm) results.	A 749		

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MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 749	Continued From page 28 The Clark County Health District TB (Tuberculosis) Treatment and Control Department form dated 3/13/07, indicated Employee #25 was a "Converter", and that INH (Isonicotinic Acid Hydrazide) therapy was recommended but not started. There was no documented evidence that Employee #25 received treatment and/or therapy following the positive Tuberculin results in 2007. There was no documented evidence that the employee was screened by a medical professional for signs and symptoms of active Tuberculosis following the positive conversion. Interview On 7/24/08 in the afternoon, the Infection Control Nurse stated that she was aware of the employee's positiveTtuberculin testing results; however, she was unsure whether the positive results were due to the employee's exposure to Tuberculosis. The Infection Control Nurse further verified that Employee #25 did not receive treatment and/or therapy following the positive Tuberculin results in 2007. 2. Blood droplets in the Cath Lab Observation On 7/25/08 at 9:35 AM, in the Cardiac Catheterization (Cath) Lab prior to the next procedure, 4 drops of blood were observed at the foot of the procedure table. The drops were small in size, approximately 0.5 mm in diameter, and bright red in color. The drops were observed at the end and to the left of the procedure table.	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 749	Continued From page 29	A 749		

On the right side of the foot of the procedure table, 3 pieces of small white paper and a plastic cap that covered the insertion port of an intravenous (IV) bag of fluid were lying on the floor. The pieces of paper and the plastic cap were close to the base of the procedure table. A registered nurse (RN) placed the paper and plastic cap in a trash container after she was asked what it was doing on the floor.

Interview

On 7/25/08 at 9:40 AM, staff in the cath lab reported, "We mop up after every case."

On 7/25/08 at 2:35 PM, the Director of Cardiac Services reported the cath lab staff was responsible for cleaning the rooms "after each case." The cleaning described included the "trash, floor, wiping everything down."

There was inadequate cleaning of the cardiac catheterization lab on 7/25/08 in between morning cases, resulting in an environment that was not sanitary and did not prevent a potential exposure to a source of infectious communicable diseases.

3. Lack of Outpatient Endoscopy and Cath Lab Infection Control Monitoring

Interview

On 7/23/08 at 3:20 pm, the Director of Surgical Services reported "all patients are treated the same. There are no out patients per say." The director went on to indicate there was no outpatient surgery department only outpatient services for "blood draws and x-rays."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290039	A. BUILDING _____ B. WING _____	07/25/2008

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MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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A 749	Continued From page 30 On 7/25/08 at 8:00 am, the Director of Surgical Services indicated "the pre-op (pre-operative) RN does a follow-up phone call within 24 hours staffing permitting" for patients who had an EGD (esophagastroduodenoscopy), colonoscopy, or a procedure in the cardiac catheterization lab who were not hospital in-patients. Once the follow-up phone call was completed, there was no other contact with the patient(s). The Director of Surgical Services reported there was no hospital-based monitoring of potential post-procedure infections for these patients who were not hospital in-patients. On 7/25/08 at 11:12 am, the Infection Control Officer indicated there was no infection control follow-up for patients who were not hospital in-patients and had an EGD, colonoscopy, or a procedure in the cardiac catheterization lab. On 7/25/08 at 2:35 pm, the Director of Cardiac Services indicated that there was no infection control follow-up procedure conducted for patients who had procedures in the Cardiac Catheterization Lab who were not inpatients. There was no active program for the control or investigation of infections and communicable diseases for those patients who were not hospital in-patients but had an EGD, colonoscopy, or a procedure in the cardiac catheterization lab within the surgical services area. On July 25, 2008 in the afternoon, the Infection Control Officer revealed she had no evidence of documentation for Performance Improvement, tracking and trending, or surveillance of infection monitoring for the Outpatient Endoscopy Services or the Cardiac Catheterization Outpatient	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 749	Continued From page 31 Services. Upon questioning specifically whether the facility had a system in place for monitoring of infection control for outpatients who had undergone an endoscopy and/or cardiac catheterization procedures at the facility, the Infection Control Officer responded negatively, and revealed there had not been a system in place since she was employed at the facility as the Infection Control Officer (October 23, 2006).	A 749		